PEGYLATED INTERFERON SUMMARY

PREFERRED	Pegasys vials, syringes, ProClick disposable autoinjectors, or Convenience Package (peginterferon alfa-2a), Sylatron
NON-PREFERRED	Peg-Intron/Redipen (peginterferon alfa-2b)

LENGTH OF AUTHORIZATION: For Pegasys/Peg-Intron: 1 year (365 days) for diagnosis of carcinoma; 48 weeks (336 days) for diagnoses of hepatitis B; length of authorization for hepatitis C varies based on genotype, co-infection with HIV, CD4 counts and HCV-RNA viral titers. For Sylatron: 1 year

PA CRITERIA:

For Pegasys

- Approvable for members with a diagnosis of Hepatitis B

OR

- Approvable for members with a diagnosis of carcinoma

OR

- Approvable for members with a diagnosis of Hepatitis C; Physician should submit faxed documentation of viral titer.

For Peg-Intron

- Approvable for members with a diagnosis of Hepatitis C; Physician should submit faxed documentation of viral titer.
- Physician should submit documentation of allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to Pegasys.

For Sylatron

- Approvable for members with melanoma with microscopic or gross nodal involvement (Stage III melanoma) when prescribed within 84 days of definitive surgical resection, including complete lymphadenectomy.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827.**

PA and APPEAL PROCESS:

- For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on "prior approval process".

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limit please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.

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